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ABSTRACT

Job stress in health care professionals who provide care to Acquired Immune Deficiency Syndrome (AIDS) patients has been a subject of interest to a number of health center and hospital physicians, administrators, and to some extent, behavioral scientists. In this study psychosocial correlates of burnout and depression in HIV counselors were investigated using the Maslach Burnout Inventory, the depression scale (D-Scale) of the Minnesota Multiphasic Personality Inventory (MMPI), Rotter's Internal/External Locus of Control Scale (I/E Scale) and several questionnaires containing demographic and psychological variables. The three subscales of Burnout (i.e. Emotional Exhaustion, Depersonalization, and Personal Achievement) and the D-Scale constituted the four dependent variables. Subjects (N=102) including 23 males and 79 females involved in Human Immunodeficiency Virus (HIV) counseling participated in this study. Subjects ranged in age from 21 to 71 years old. Univariate and multivariate analyses were employed to determine the contributing factors of Burnout and Depression amongst HIV counselors. Results suggested that both dispositional and environmental factors play a role in the experience of burnout and depression among HIV counselors. Prominent among the variables affecting both Emotional Exhaustion and Depersonalization was the impact of the working environment and job demands faced by HIV counselors. (ABL)

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PSYCHOSOCIAL CORRELATES OF BURNOUT AND DEPRESSION IN HIV COUNSELORS

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Abstract

Psychosocial correlates of burnout and depression in HIV counselors were investigated using Maslach Burnout Inventory, the depression scale (D-Scale) of the Minnesota Multiphasic Personality Inventory (MMPI), Rotter's Internal/External Locus of Control Scale (I/E Scale) and several questionnaires containing demographic and psychological variables. The three subscales of Burnout (i.e., Emotional Exhaustion (EE), Depersonalization (DP) and Personal Achievement (PA)) and the D-Scale constituted the four dependent variables. One hundred and two subjects, 23 males and 79 females, involved in HIV counseling participated in this study. Subjects' ages ranged from 21 to 71 with a mean of 38.6 and a standard deviation of 11.6 years. Univariate and multivariate analyses were employed to determine the contributing factors of Burnout and Depression amongst HIV counselors. Implications for the development of early detection and establishing prevention programs are discussed.

Stress Factors and Health Care Providers

The Human Immunodeficiency Virus (HIV) is the retrovirus responsible for Acquired Immune Deficiency Syndrome (AIDS) which is the final stage of a continuum of illnesses related to HIV infection (Flaskerud, 1989). The profound sociocultural impact of AIDS has led to the argument that for cultural analysts, the 1980s and beyond are the AIDS years (Bosk & Frader, 1990). The French anthropologist Marcel Mauss has called AIDS a "total social phenomenon-one whose transactions are at once economic, judicial, moral, aesthetic, religious and mythological, and whose meaning cannot, therefore, be adequately described from the point of view of any single discipline" (Hyde, 1979). The global effects of AIDS are not matched by any other disease in our lifetime and involve every sector of the health care provision system (Piemme & Bolle, 1990) including individuals whose jobs involve the delivery of health care.

Job stress in health care professionals who provide care to AIDS patients has been a subject of interest to a number of health center and hospital physicians, administrators, and to some extent, behavioral scientists (Blumenfield, Smith, Milazzo, Seropian & Wormser, 1987; Bosk & Frader, 1990; Douglas, Kalman & Kalman, 1985; Eastham, Thompson & Ryan, 1991; Klonoff & Ewers, 1990; LeBourdias, 1989; Loewy, 1988; Piemme & Bolle, 1990; Ross & Seeger, 1988; Scott & Jaffe, 1989; Sorensen, Costantini & London, 1989; Wallack, 1989). The majority of studies to date have concentrated on physicians and nurses who provide medical care for the HIV positive and AIDS patients (Blumenfield et al., 1987; Bosk & Frader, 1990; Douglas et al., 1985; Eastham et al., 1991; Klonoff & Ewers, 1990; LeBourdias, 1989; Loewy, 1988; Ross & Seeger, 1988; Wallack, 1989). However, HIV counselors, professionals who provide pre-test and post-test counseling to individuals who are tested for the antibody to the HIV virus, constitute another important health-care delivery group for which there is no empirical data on the effects of job-related stress. The present study however, suggests that a variety of disturbing occupational stress factors are present in this professional group.

A number of previous studies, while not focusing on the stress-related factors, have looked at attitudinal responses of health care professionals toward HIV positive and AIDS patients. For example, investigating the attitudes of health care professionals, a physician with the Beth Israel Medical Center in New Your City examined the attitudes of 67 house staff physicians and 172 nurses with respect to providing care for AIDS patients (Wallack, 1989). The responses of 65% of the house staff and 63% of the nurses indicated that they are afraid of contracting AIDS in spite of following the hospital's infection control guidelines. In addition to fear of AIDS, three physicians (5%) and eighteen nurses (11%) in this sample endorsed the item stating that AIDS is God's punishment to homosexuals; Wallack believes that religious preference, although not statistically significant, may have influenced nurses' responses to that item. Yet, whether such negative beliefs were a result of prejudice against homosexuals or the stress involved in caring for AIDS patients was not sorted out in this study.

In another study, Eastham et al. considered treatment and career attitudes of emergency medical response (EMS) workers associated with potential exposure to HIV/AIDS (Eastham et al., 1991). Their attitude scale, AIDSTRESS, consisted of eight questions regarding job stress. Thirty eight percent of the respondents stated that if they had the choice they "would avoid providing treatment to HIV/AIDS patients." Eighteen percent of the respondents stated that they have considered resigning from the emergency medical response work. Advanced life support (ALS) providers, compared to basic life support (BLS) providers reported higher job stress. The important demographic and job-related factors were found to be gender, paid vs. volunteer work, number of years of field experience, education, providing care in an urban vs. rural area, and the level of satisfaction with their HIV training.

A minority of health care professionals have expressed their desire not to provide care for AIDS patients; because of this, the professional and moral obligations of health care providers has been called into question by some investigators (Loewy, 1988).

Katz et. al. (1987) measured the attitudes of college students, nurses, medical students, and chiropractic students towards cancer, AIDS, diabetes, and heart disease patients, as well as the nonill. Subjects answered 21 bipolar trait items measuring their attitudes towards patients' competence, moral worth, dependence, depression and morbidity. Measures of social distance, cancer anxiety, disease beliefs, and ascribed illness responsibility were also included. Cancer patients, although rated as more depressed than AIDS patients, were considered as favorably as the nonill on a measure of moral worth. The people who were most negatively evaluated in terms of their moral worth were people with AIDS.

Blumenfield, et al. (1987) have looked at attitudes of nurses who work with AIDS patients. Using a ten item true/false questionnaire they found that the family and friends of two thirds of the nurses expressed concerns about the nurses' association with hospital personnel who were in contact with AIDS patients. Through informal reports, some nurses stated that their friends, families and neighbors shunned them after they realized the nurse worked with AIDS patients. In some cases, the spouses of nurses who worked with AIDS patients became reluctant to let the nurses get too close to their children.

The contradiction between professional responsibility for restoring function, occupational role, and relationships (i.e., helper versus fatalist) for a group of occupational therapists dealing with AIDS patients was reported by Piemme and Bolle (1990). These authors point out that occupational therapists experience grief reactions that are similar to patients' grief reactions and may include depression, avoidance, anger, feelings of helplessness and guilt, as well as somatic complaints. The investigators argue that the job of the occupational therapist is particularly stressful because of the high mortality rate of the disease, the fact that the majority of the infected clients are young and at the prime of their lives, and the conflict created by providing services to someone who will eventually die.

Sorensen, et. al. (1989) looked at burnout and coping strategies in patients and staff of drug abuse

treatment programs. They point to counselors' countertransference issues, i.e., a counselor's emotional reactions toward AIDS-affected injection drug users (IDUs). The counselors often have difficulty setting limits as to how far they can go without being overprotective or overinvolved. The investigators pose the following questions: "what should a counselor do when a seropositive patient is sexually active but not using condoms, when a patient becomes pregnant, when a patient refuses needed medical treatment of AIDS or when a patient commits suicide? . . . should the counselor go to the home of a patient who has not been attending the clinic regularly? How often should the counselor visit patients in the hospital? Should the counselor go to a public memorial service?" (Sorensen et al., 1989, pg. 438). These concerns are not limited to drug abuse counselors alone as all counselors dealing with HIV-positive and AIDS patients face these same dilemmas from time to time. Counselors may see themselves in their patients, Sorensen asserts, and because this potential "overidentification" can make it difficult to provide treatment in a rational manner, it clearly can be a personal stress on the counselor.

Other researchers investigated the attitudes of health care providers with respect to homophobia. Douglas et al. (1985) in particular, looked at levels of homophobia among physicians and nurses. They used the Index of Homophobia (IHP) questionnaire developed by Hudson and Ricketts (Hudson and Ricketts, 1980). They discovered that while the mean score for both physicians and nurses fell in the low-level homophobic range, about ten percent of respondents endorsed the statement "homosexuals who contract AIDS are getting what they deserve" (Douglas et al., 1985, p. 1310)

Ross and Seager (1988) conducted a study in two teaching hospitals in Australia. The subjects included a group of 4 physicians, 64 registered nurses, 24 enrolled nurses, and 16 paramedical staff (social workers, occupational therapists, clerics, dieticians and psychologists). They asked the following questions using a five point likert scale: the extent that working with AIDS patients had led to more stress, depression, anxiety, overwork, and intellectual stimulation; the need for more information to deal with

physical and emotional needs of patients with AIDS; the degree to which the respondent had thought more about homosexuality and intravenous drug use since starting to care for patients with AIDS; and the degree to which they had known any homosexual people or intravenous drug users prior to starting to care for the patients with AIDS. Using a similar scale, respondents were also asked to indicate which aspects of working with AIDS patients they found most stressful, the extent to which they had felt burned out working with AIDS patients, and the extent to which they thought they were at risk of being burned out in future from such work. They concluded that the highest correlate for current burnout was "stress, followed by needing more information about patients' emotional needs, need for a support group, more thought about the issue of intravenous drug use, and depression and anxiety. The highest correlates of anticipated burnout were again needing more information on patients' emotional needs, followed by distress over the neurological aspects of AIDS and the youth of patients" (Ross & Seeger, 1988, p. 396).

While most researchers have looked at the stressors and attitudes of physicians and nurses who work with AIDS patients, as Klonoff and Ewers (1990) have suggested, more attention needs to be paid to the attitudes and psychological responses of nonmedical employees of health care facilities. These employees, including the clerical support staff in outpatient units, often have numerous contacts with HIV positive and AIDS patients and may be experiencing severe job related stress. In addition, while few researchers have considered the effects of stresses upon non-HIV counselors, factors that may lead to stress and burnout in HIV counselors have not been empirically investigated.

A most promising model of burnout among health care professionals has been proposed by Christina Maslach (1981) in which she defines burnout as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (Maslach & Jackson, 1981, p. 99). She describes health care professionals who experience burnout as emotionally

exhausted and having a more difficult time genuinely feeling and caring for their patients; they are also purported to have cynical and negative attitudes towards their clients. Once a health care professional is emotionally exhausted, s/he may view clients as somehow deserving of their troubles, the so-called "blaming the victim" phenomena (Ryan, 1971; Maslach & Jackson, 1981). Thus, in the review of stress factors research with health care providers, it is not at all clear whether the negative attitudes of physicians and nurses reported by researchers is a symptom of burnout, i.e., a syndrome of emotional exhaustion related to psychosocial stress, or a general attitudinal response towards AIDS patients and/or homosexuals.

The implications of determining these psychosocial correlates of stress are substantial for health care delivery, cost effectiveness of programs, as well as the development of measures of prevention and early intervention of problem areas with professional staff. Numerous studies have suggested that burnout could result in a deterioration in the quality of care and services provided by the staff (Freudenberger, 1974, 1975; Maslach, 1976, 1978a, 1978b, 1979; Maslach & Jackson, 1978, 1979, 1982; Jackson & Maslach, 1980; Maslach & Pines, 1977; Pines & Maslach, 1978, 1980). Burnout appears to be a factor in job turnover, absenteeism, low morale, physical exhaustion, insomnia, increased use of alcohol and drugs, marital and family problems, and a negative self evaluation on the part of the care provider (Maslach & Jackson, 1981). Because burnout has serious consequences in the helping profession, it is important to determine the correlates of burnout, that is, factors which contribute to the experience of burnout among health care professionals. The purpose of this study is to determine psychosocial correlates of burnout and depression among professionals who are involved in HIV testing and counseling.

HIV Testing and Counseling

HIV testing is a two part process: pre-test counseling and post-test counseling. At the time of pre-test counseling the client is provided with HIV/AIDS education. Safe-sex and drug use education and their relationship to HIV transmission are also discussed and the individual's risk of being HIV infected is assessed; blood is drawn at this time and the client is asked to return in one to three weeks to receive his/her test results. At the time of post-test counseling the client is provided with HIV results. In addition, safe-sex and drug use education are repeated. Finally, the individual's psychological status is assessed to ensure that he/she is ready to leave the counseling room. Because no definitive cure for AIDS has been found, the job of the HIV counselor has been a difficult one.

Post-test counseling a HIV-positive individual is perhaps the most stressful task in the entire process; there are a number of reasons which could contribute to that stress: the individual may break into tears, may project his/her anger at the counselor or may become silent in disbelief. These are some of the expected reactions. Such expectation may result in anxiety prior to and during the scheduled counseling session. Also, to tell an individual that she/he is HIV-positive might seem like giving the person a death sentence. Another source of anxiety and frustration in HIV counselors is the lack of willingness of some HIV positive clients to inform their sexual or IV-drug using partners of their HIV-positive status. This can also lead to feelings of helplessness in HIV counselors since they are bound by strict legal and ethical confidentiality laws which prevent them from being able to inform the patient's partners. The counselor might view his/her inability to convince the client to inform the partners as a personal failure. While stresses involved in post-test counseling a HIV-positive individual might be obvious, difficulties in providing post-test counseling to a HIV-negative individual, and also in providing pre-test counseling, are often overlooked.

One of the difficulties in post-test counseling a HIV-negative individual is to inform him of the "window period"; the period during which a client may seroconvert. Currently available laboratory tests

for HIV are HIV antibody tests. These tests are designed to detect the existence of antibodies to the HIV virus. Once an individual becomes infected with HIV, it may take the body between two weeks to six months to produce the antibodies to the virus. This will leave a "window period" during which antibodies to HIV might not be detected by the currently available tests. If a person is in this window period, his/her test results will be negative but he/she will be a carrier of the HIV virus and can pass it on to others. Because of this window period, individuals whose test results are negative and who had engaged in unprotected sexual activities and/or needle sharing prior to the test, are strongly encouraged to abstain from any high risk behavior and to return for a second test after six months. It is only after this second test, with the provision that the individual has abstained from all high risk behaviors, that a client's negative test result can be considered as being truly negative; otherwise it may be a false negative. It is often difficult to describe the "window period" to clients. Once individuals are informed about their negative HIV antibody status they react with a sense of relief; it is often stressful for the counselor to challenge this relief and explain the "window period", informing the client that another test is needed. One can see that not only post-test counseling a HIV-positive patient could be stressful, post-test counseling HIV-negative individuals could be stressful as well. Post-test counseling HIV-negative and HIV-positive clients may not be the only sources of stress however; pre-test counseling could be stressful on its own.

During AIDS education, at the time of pre-test counseling, clients are often uneasy talking about sexual issues or may be in denial of their risk of HIV infection. To try to break such denials are often difficult and stressful for the counselor. In clinics in which the primary purpose of the client's visit is not HIV testing (i.e. drug rehabilitation clinics, sexually transmitted disease clinics, tuberculosis clinics, etc.) an added job stressor of the HIV counselor is to try to encourage the client to take the HIV test. This is an important aspect of pre-test counseling because the sooner an infected individual learns of

his/her HIV status, the sooner he/she can begin medical intervention and the sooner he/she can stop infecting other people. The counselor experiences frustration in that many people at high risk for HIV are not interested in taking the test; the counselor might view this as his/her inability to provide effective pre-test counseling. Additionally, in many such clinics counselors are expected to convince a number of people to test; the counselors may feel they have a quota to meet and thus feel pressured to test a number of individuals to maintain their jobs.

Like so many other fields of counseling the salary of HIV counselors is often low and financial hardship cannot be excluded as a source of stress. In addition, depending on the type of clinic, the counselor may have a hard time utilizing the help of the medical staff in drawing blood needed for HIV testing. The medical staff attitudes toward dealing with HIV positive and AIDS patients as well as the demands of their regular work schedule contribute to obstacles that the HIV counselor often encounters in seeking the support of the medical staff, all of which can contribute to a stressful work environment.

Methods

Subjects

One hundred and five individuals, 23 males and 82 females, involved in HIV counseling participated in this study. Data from three women were discarded because they were volunteer workers; the sample therefore consisted of 23 males and 79 females. Their age ranged from 21 to 71 with a mean of 38.6 and a standard deviation of 11.6 years. There were 6 Asians, 32 African Americans, 30 Latinos and 30 Caucasians in this study; ethnicity information on 4 subjects was missing. Subjects were drawn from 11 county clinics and 13 private clinics in the greater Los Angeles area. Participation was voluntary and anonymous.

Instruments

Maslach's Burnout Inventory (MBI) (Maslach, 1986) was used to determine the degree of burnout in HIV counselors. MBI is designed to determine three aspects of burnout: Emotional Exhaustion (EE), Depersonalization (DP) and Personal Achievement (PA) (Maslach & Jackson, 1986a). A typical question in MBI is: "Working with people all day is really a strain for me" and responses are based on a seven point, likert-type scale ranging from 0 "never" to 6 "every day". Individuals who are highly burned out, score high on the EE and DP subscales and low on the PA subscale. Individuals who experience average burnout, score average on the three subscales and those experiencing low levels of burnout score low on the EE and DP subscales and high on the PA subscale. The scores on the three subscales are considered separately and are not to be combined into a total score (Maslach & Jackson 1986a).

The depression scale (i.e. D-Scale) of the Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & McKinley, 1970) was used to assess the degree of depression in HIV counselors and to look at factors contributing to depression in this professional group. There are sixty true/false questions in the depression scale of MMPI. A typical MMPI D-Scale item is "I usually feel that life is worth while." Responses endorsing depression were summed and transformed into T-scores, thus providing a continuous variable for depression.

Rotter's Internal/External Locus of Control Scale (I/E Scale) (Rotter, 1966) was used to determine whether internality or externality of the locus of control would be a factor associated with burnout. Locus of Control is a construct derived from Rotter's social learning theory (Rotter, 1954). According to Rotter, externally oriented individuals associate their life events with chance occurrences, luck or fate, or believe that their lives are controlled by powerful external forces. In contrast, an internally oriented individual perceives events to be contingent upon his/her behavior or characteristics (Rotter, 1966).

A questionnaire was developed to assess the psychosocial aspects of a counselor's work environment and the various stressors in the job setting. An additional questionnaire was used to

determine a number of demographic variables including gender, age, degree of religious beliefs, marital status and education.

Protocol

All assessment forms, in addition to an instruction sheet, were placed in a manilla envelope that could be sealed. Subjects were each given one such manilla envelope and were asked not to write their names anywhere on the assessment forms or the envelope to ensure complete anonymity. Each battery of assessment forms, which took about thirty minutes to complete, was sealed and returned to a designated clinic staff member. Envelopes were then collected by the researchers.

Methods of Statistical Analysis

Analyses of data were performed using the PC SAS (SAS Institute Inc., 1985) statistical package in two separate procedures: first, simple correlations between the four dependent variables (Emotional Exhaustion (EE), Depersonalization (DP), Personal Achievement (PA), Depression (D)) and a number of predictor variables were calculated. A stepwise multiple regression analysis was then performed on the variables to determine the strength of each variable's contribution to the overall predicted variance.

Data from 45 of the 102 individuals who participated in the study had missing values. A listwise deletion of variables was employed which eliminated those cases where missing values were found. As a result, the effective sample size for the stepwise multivariate analysis was N=57. A t-test comparison of the group with missing values and the group without missing values revealed no significant differences between the two groups in any of the dependent variables (i.e., EE, DP, PA and MMPI-D-Scale).

Table 1 provides a list of predictor variables, their definitions and coding formats. A number

of demographic questions were dichotomized for the purpose of stepwise analysis.

Insert Table 1 about here

The dichotomized variables were as follows: clinic type was dichotomized into "county clinics" and "private clinics"; ethnicity was dichotomized into "Caucasian" and "other"; marital status was dichotomized into "married" and "other"; educational level was dichotomized into "less than a bachelors degree" and "bachelors degree or higher"; primary area of work was dichotomized into "medical" and "other" (i.e., counseling, social work, etc.); and level of primary position was dichotomized into "staff member" and "other" (i.e., administrator, supervisor and manager).

Results

Table 2 provides means, standard deviations and correlations of the 28 predictor variables with Emotional Exhaustion, Depersonalization, Personal Achievement, and Depression.

Insert Table 2 about here

As indicated in Table 2, Emotional Exhaustion (EE) is significantly correlated with the following predictor variables: Locus of control (internal versus external) ($r = .24$); post-test counseling ($r = .31$); medical staff cooperation ($r = -.29$); pressure to test a lot of people ($r = .30$); job stress ($r = .38$); frequency of supervisor requesting unreasonable job-related tasks ($r = .29$); and, job satisfaction ($r = -.26$).

The Depersonalization (DP) dependent variable is significantly correlated with job satisfaction ($r = -.22$).

The Personal Achievement (PA) dependent variable is significantly correlated with the following predictor variables: type of clinic (private versus county) (r=-.20); race (caucasian versus non-caucasian) (r=-.29); primary area of work (non-medical versus medical) (r=-.24); number of hours of work per week (r=-.26); degree of medical staff cooperativeness (r=.26); adequacy of time available for education and counseling of each client (r=.33); job satisfaction (r=.29); support from the employer (r=.26); and, support from colleagues (r=.27).

The Depression (D) dependent variable is significantly correlated with the following predictor variables: Locus of Control (internal versus external) (r=.31); Gender (female versus male) (r=.22); strength of religious beliefs (r=-.31); pressure to test a lot of people (r=.31); and, job satisfaction (r=-.25).

A stepwise multiple regression analysis was performed on the predictor variables for each of the dependent variables. A summary of the stepwise multiple regression analysis for emotional exhaustion (EE) is presented in Table 3.

Insert Table 3 about here

Three variables accounted for 36% of the variance in the criterion variable of Emotional Exhaustion (EE). The predictive ability of the model was statistically significant ($F=10.25$, $p< 0.0001$), with a multiple $R=.60$. The characteristic pattern of the emotionally exhausted HIV counselor is one who is likely to have an external locus of control, i.e., needing structured support from the work environment; is likely to report that the job is very stressful, and does not receive cooperation from the clinic medical staff in doing his/her job.

Table 4 presents the three highly significant variables ($F=8.77$, $p<.0001$) that entered the

stepwise analysis and are predictive of 33% of the variance attributable to the Depersonalization (DP) subscale of burnout:

Insert Table 4 about here

These predictor variables would support the picture of a counselor who is externally oriented and looks for direction, support and structure in the work environment; is married and feels pressured to test many people in order to maintain his/her job.

Personal Achievement (PA) was the next variable analyzed in the stepwise model. A multiple R of 0.72 was achieved in this model accounting for 52% of the variance of the Personal Achievement subscale of burnout. Once again the model was statistically significant ($F = 14.28$, $p < 0.0001$).

Insert Table 5 about here

In as much as a high degree of perceived Personal Achievement is indicative of a low burnout level, the four variables predictive of Personal Achievement paint the picture of a counselor who does not feel time pressured and has enough time to provide counseling to each client, feels supported by the medical staff, recognizes his/her limits as to the amount of control he/she has over the way the job is done and yet is internally oriented, doesn't need constant supervision and is self-reliant. The final variable analyzed by the stepwise analysis was Depression.

Insert Table 6 about here

Table 6 presents the five significant variables ($F = 15.22$, $p < .0001$) which entered the stepwise model for Depression and accounted for 59% of the variance in this dependent variable. According to this model, a depressed counselor tends to have an external locus of control, needing a lot of direction and supervision at work, looks for emotional support among his/her colleagues and finds them supportive, does not have strong religious beliefs, provides post-test HIV counseling, and recognizes the limits of how much control he/she has over the way the job is done.

Conclusion and Discussion

In addition to people living with AIDS and those who are asymptomatic but are infected with the virus, HIV has also had a profound impact on the professional and personal lives of many health care workers who provide services to the HIV infected patients. A subgroup of health care professionals providing HIV/AIDS related services are the HIV counselors whose responsibilities include the delivery of pre and/or post-test HIV counseling. Among health care professionals who work with HIV infected individuals, HIV counselors are unique in that they are often the first to break a patient's denials about AIDS by providing AIDS education and encouraging the patient to take the HIV antibody test. Also, HIV counselors are often the first professionals to inform the patient of his/her HIV status. These "frontline" responsibilities are among the factors that contribute to the stressful nature of the profession of HIV counseling and can lead to burnout and depression in this professional group.

One finding of this study that points to the importance of including social stress factors in evaluating the sources of stress in HIV counselors was that married individuals are more burned out than unmarried ones (i.e., single, divorced, widowed, and separated). Blumenfield, et al. (1987) who studied the attitudes of nurses working with AIDS patients, reported that the family and friends of many nurses expressed concerns about the nurse's association with hospital personnel who were in contact with AIDS

patients. It is likely that in our group as well married counselors experienced more job related psychosocial pressures from home than those who were not married. In addition, married counselors who have children may face escalating worries about the future of their children whose eventual sexual activity may lead to exposure; HIV counseling may be a constant reminder of this fear.

These data suggest that both dispositional and environmental factors play a role in the experience of burnout and depression amongst HIV counselors. Prominent among the variables affecting both Emotional Exhaustion and Depersonalization was the impact of the working environment and job demands faced by HIV counselors. Simply stated, when these HIV counselors experience their work environment as not meeting their psychological needs (e.g., no emotional support), they often experiences job-related burnout and depression. Conversely, these data also reveal that a sense of personal achievement and realistic goal attainment was characteristic of staff who felt supported by their colleagues and the agency for which they work. In sum, they were less burned out than those who did not feel supported.

These data confirm for us that early assessment and recognition of these psychosocial aspects of the work environment would prove advantageous to the development of prevention programs for burnout and depression in this professional group. In this regard, the practical value of staff support groups and agency-encouraged attendance cannot be overemphasized (LeBourdais, 1989; Scott & Jaffe, 1989; Sorensen, Costaniti, & London, 1989).

One promising model of support that may be usefully applied to the HIV/AIDS health care professional, is proposed by Scott and Jaffe (1989). The authors point to the "counterproductive and stress-inducing inner attitudes and expectations about the work" that is prevalent among all health care providers (pg. 86). They argue that some beliefs of health care professionals such as "there should be no personal needs or feelings" or "one should be always and immediately available to patients", or "one should be able to produce health or make a difference" are unreasonable expectations which facilitate the

health care professional's emotional withdrawal and denial of his/her personal feelings, which in turn lead to burnout. The intervention model proposed by Scott and Jaffe consists of three levels: the primary intervention includes "increasing the health-care worker's knowledge and self-awareness; changing attitudes about the ability to handle stress; increasing stress-resistance skills, such as social support, control, assertiveness, and interpersonal communication; [and] awareness-building/attitude changing activities" (pg.89). Their secondary intervention involves "healing identified patients"; this can be achieved by "an Employee Assistant Program that provides free or co-pay counseling and referral for any type of stress or life problem . . . establishing networks of referrals and insurance coverage for counseling; training for identified highly stressed individuals and groups who are urged or required to attend; [and] implementation of sick leave, vacation, and intervention for burnout and stress" (pg.92). Their tertiary intervention includes an active "confrontation of and intervention with distressed workers" and reorganization and team development to prevent future cases of burnout in a dysfunctional organization; it also suggests outpatient or inpatient treatment programs for severely affected individuals.

It should be emphasized that without the support and encouragement of supervisors, the counselor might often shy away from leaving his/her busy work schedule to participate in support groups. A concerted effort at the organizational level is therefore needed. This points to the importance of improved supervisor-employee relationships as one prevention method for burnout. As the results of the present study suggest, counselors who feel pressured to test many people to maintain their jobs, those who believe their supervisors had unreasonable job-related requests and others who were rushed and did not have adequate time for counseling, were more burned out than their less pressured colleagues. Work pressures beyond those already inherent in such a high-stress profession can clearly be damaging to the psychological well-being of HIV counselors.

Clinic and hospital management need to recognize the psychologically taxing nature of HIV counseling, particularly post-test counseling. At times, after a difficult post-test counseling session, the counselor may need an hour to be alone and away from work; such requests should not be taken lightly and should be granted. In fact, one of the most supportive clinics we encountered allowed for "mental health time" and "mental health days" for all their staff.

While support groups are important in prevention and intervention of burnout at the group/environmental level, the importance of individual differences as predisposing factors to burnout should also be recognized. For example, since individuals with an external locus of control are more likely to suffer from burnout and depression, they should be provided with more support, supervision and instruction. They should be reminded that they can and do indeed make an impact in the lives of their clients. Externally oriented counselors and those who may have high expectations of themselves should be reminded of the need to recognize the limitations of what they can and cannot achieve and the necessity of setting realistic goals in patient care. These individuals would particularly benefit from workshops on how to set personal boundaries between themselves and their clients to protect themselves from burnout.

Individual differences also manifest themselves in the way some HIV counselors suffer from what has been termed "survivor guilt" (Hortsman & McKusick, 1986). A health care worker who is experiencing survivor guilt often asks him/herself questions like "why is this patient infected and I am spared?" Because this "survivor guilt" and the inability to provide cure may bring a sense of professional impotence among counselors, they need to be reminded of what they are able to provide for their clients. For example, they can provide the client with much needed education about HIV and AIDS; can empower the HIV-positive client with hope, and help him/her to maintain a positive attitude. The HIV counselor can and should take pride in that he/she is educating and testing clients who may otherwise continue

engaging in high risk behaviors which could endanger their lives as well as the lives of others.

Not only do counselors need to learn to protect themselves against burnout and depression, it is essential that their supervisors are also aware of factors that can lead to burnout. Supervisors and clinic managers should be able to recognize early signs of burnout and depression in order to provide appropriate interventions. The question "How satisfied are you with your job?" was of particular interest in this study because counselors who reported being more satisfied were less emotionally exhausted (EE), had a lower degree of depersonalization (DP), scored higher in personal achievement (PA), and were less depressed. In other words, that question on its own was highly predictive of burnout and depression. The above is a question that can casually and frequently be asked from the counselors to determine their proneness to burnout and depression. Supervisors are therefore encouraged to facilitate open communication so that such informal assessments of counselors' psychological well-being would be possible.

While this study has delineated some of the correlates of burnout and depression, it is important to point to some of its limitations. The study was conducted in Los Angeles County which is one of the major HIV epicenters in the United States. HIV prevalence rate in some populations in Los Angeles County is considerably lower than similar populations in some other major metropolitan areas. For example, the impact of the epidemic is much greater among intravenous drug users in New York City than in the same population in Los Angeles. Thus, each post-test counselor in Los Angeles is less likely to have to reveal positive test results when compared to his/her counterpart in New York City. To derive at a national picture of burnout and depression in HIV counselors, a study with a much wider scope and with careful random sampling would be desirable. Another factor of importance is our operational definition of an HIV counselor. There are very few individuals in the Los Angeles County who are exclusively HIV counselors. HIV counseling is often only a part of a health care professional's duties;

therefore, some individuals who provide HIV counseling are nurses while others are social workers. A more accurate picture of burnout and depression in HIV counselors will be possible only if comparisons are made between nurses and social workers involved in HIV counseling and those, in the same types of occupations, who do not provide HIV counseling. To that extent, this study is only a preliminary look at psychosocial aspects of burnout and depression in HIV counselors.

In summary, without prevention and intervention, HIV counselors are very likely to suffer from burnout and depression; once burned out, the quality and quantity of their work is likely to be negatively affected. Counseling and management staff would benefit from learning about psychosocial factors that are correlated with burnout and depression. Such knowledge could be instrumental in the development of early prevention programs. It can also help the counselors to recognize, in themselves as well as in their colleagues, the early signs of burnout and depression and take a break from their job, or seek help. HIV counselors are important professionals in our fight against AIDS; they should not become another victim of this epidemic.

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Table 1

Definitions and Coding of Selected Demographic and Psychological Variables Used as Predictors of Burnout and Depression In Stepwise Multiple Regression Analysis

Variable Number	Description
1	"Clinic ID"; Coded: 0=Private Clinics, 1=County Clinics
2	"Rotter" I/E Scale; Scored in increasing externality of Locus of Control
3	"Gender"; Coded: 0=Female, 1=Male
4	"Age"; entered in number of years
5	"Race"; Coded: 0=Caucasian, 1=non-caucasian
6	"Strength of religious beliefs"; Coded: 1=not at all religious to 7=very religious
7	"Marital status"; Coded: 0=Non-Married (i.e. single, divorced, widowed, separated), 1=Married
8	"Highest educational level completed"; Coded in increasing educational level (i.e. 1=completed high school, 2=some college, 3=completed four years of college, 4=some postgraduate work or degree)
9	"Primary Area of Work"; Coded: 0=Non-Medical (i.e. mental health, education, social services, counseling), 1=Medical
10	"Level of primary position"; Coded: 0=Staff member, 1=Supervisor (i.e. supervisor, administrator, trainer)
11	"Number of hours of work per week"
12	"Length of employment at present job"; Entered in number of months
13	"Length of employment in current general type of work"; Entered in number of months
14	"Number of HIV positive patients the counselor interacts with per month"

Table 1 (Continued)

Variable Number	Description
15	"Number of hours the counselor spends in pre and/or post-test counseling in a typical day"
16	"Pre-test HIV counseling is part of the counselor's duties"; Coded: 0=No, 1=Yes
17	"Post-test HIV counseling is part of the counselor's duties"; Coded: 0=No, 1=Yes
18	"Degree of medical staff cooperativeness"; Coded: 0="Not Cooperative" to 4="Fully Cooperative"
19	"Adequacy of the amount of time available to provide education and counseling to each client"; Coded: 0="Not Adequate" to 4="Highly Adequate"
20	"Degree of pressure to test a lot of people in order to maintain ones job"; Coded: 0="Not at all Pressured" to 4="Highly Pressured"
21	"Adequacy of salary"; Coded: 0="Not Adequate" to 4="Highly Adequate"
22	"Perceived control over the way their job is done"; Coded: 0="No Control" to 4="Full Control"
23	"Degree to which the work load is demanding"; Coded: 0="Not Demanding" to 4="Extremely Demanding"
24	"Degree of job stress"; Coded: 0="Not Stressful" to 4="Extremely Stressful"
25	"Frequency of supervisor requesting unreasonable job-related tasks"; Coded: 0="Never" to 4="Always"
26	"Degree of satisfaction with the job"; Coded: 0="Not Satisfied" to 4="Extremely Satisfied"
27	"Level of support received from the agency that pays the salary"; Coded: 0="Not Supportive" to 4="Fully Supportive"
28	"Level of support received from other staff members"; Coded: 0="Not at all Supportive" to 4="Fully Supportive"

Table 2

Mean (M), Standard Deviation (SD) and Correlations (r) with Emotional Exhaustion (EE), Depersonalization (DP), Personal Achievement (PA) and Depression (D) for the 28 Predictor Variables Entered in the Stepwise Multiple Regression Analysis

Predictor Variable	M	SD	r(EE)	r(DP)	r(PA)	r(D)
1	0.50	0.50	-0.08	0.15	-0.20*	-0.17
2	9.69	3.89	0.24*	0.19	-0.18	0.31**
3	0.23	0.42	0.02	0.120	0.07	0.22*
4	38.55	11.57	-0.18	-0.18	0.00	-0.17
5	0.69	0.46	-0.03	0.03	-0.29**	0.08
6	4.03	1.75	-0.17	0.00	-0.02	-0.31**
7	0.48	0.50	0.02	0.17	-0.14	-0.02
8	2.9	0.92	0.17	0.10	-0.01	-0.07
9	0.46	0.50	-0.04	-0.02	-0.24*	-0.08
10	0.22	0.42	-0.05	-0.12	0.17	0.10
11	37.22	8.12	0.02	0.10	-0.26*	0.03
12	61.72	76.79	-0.14	0.01	-0.05	-0.06
13	134.38	120.45	-0.06	-0.06	-0.01	-0.15
14	4.76	14.22	0.12	0.05	0.18	0.02
15	3.47	2.21	0.06	0.02	0.02	-0.16
16	0.99	0.10	-0.08	0.08	0.08	-0.07
17	0.74	0.44	0.31**	0.15	0.05	0.16
18	3.01	1.03	-0.29**	-0.16	0.26**	-0.13
19	2.19	1.01	-0.10	-0.12	0.33**	-0.02
20	1.02	1.19	0.30**	0.12	-0.10	0.31**
21	1.25	0.99	-0.02	-0.03	0.10	-0.14
22	2.44	0.90	-0.14	-0.16	0.12	0.09
23	2.24	0.77	0.04	0.05	0.05	-0.06
24	1.80	0.79	0.38**	0.18	-0.10	0.11
25	0.73	0.74	0.29**	0.19	-0.19	0.15
26	2.39	0.86	-0.26**	-0.22*	0.29**	-0.25*
27	1.94	1.12	-0.07	-0.06	0.26*	-0.16
28	2.49	1.10	-0.12	-0.10	0.27**	-0.13

* Correlations significant at the .05 level (2 - tailed test) ** Correlations significant at the .01 level (2 - tailed test)

Table 3

Summary of Stepwise Multiple Regression

Analysis on Emotional Exhaustion (EE)

Step	Predictor Variable Entered	Partial R**2	Model R**2	F - test at Entry	Prob > F	Beta	Stan. Beta
1	2	0.20	0.20	13.96	0.0004	0.87	0.33
2	24	0.11	0.31	8.79	0.0045	4.36	0.33
3	18	0.05	0.36	4.49	0.0387	-2.51	-0.24
Intercept:						8.68	0.00
Model:	F = 10.25	p < .0001					

Table 4

Summary of Stepwise Multiple Regression

Analysis on Depersonalization (DP)

Step	Predictor Variable Entered	Partial R**2	Model R**2	F - test at Entry	Prob > F	Beta	Stan. Beta
1	2	0.16	0.16	10.63	0.0019	0.34	0.33
2	7	0.08	0.24	5.75	0.0199	3.08	0.38
3	20	0.09	0.33	7.11	0.0101	1.14	0.32
Intercept:						-0.83	0.00
Model:	F = 8.77	p < 0.0001					

Table 5

Summary of Stepwise Multiple Regression

Analysis on Personal Achievement (PA)

Step	Predictor Variable Entered	Partial R**2	Model R**2	F - test at Entry	Prob > F	Beta	Stan. Beta
1	19	0.24	0.24	17.53	0.0001	2.77	0.50
2	18	0.11	0.35	9.37	0.0034	2.34	0.40
3	22	0.09	0.44	8.33	0.0056	-2.47	-0.37
4	2	0.08	0.52	9.07	0.0040	-0.43	-0.29
Intercept:						34.96	0.00
Model:	F = 14.28	p < .0001					

Table 6

Summary of Stepwise Multiple Regression

Analysis on Depression (D)

Step	Predictor Variable Entered	Partial R**2	Model R**2	F - test at Entry	Prob > F	Beta	Stan. Beta
1	2	0.31	0.31	25.74	0.0001	1.58	0.56
2	6	0.14	0.46	14.48	0.0004	-2.16	-0.37
3	17	0.06	0.52	7.21	0.0096	7.07	0.25
4	28	0.03	0.56	4.15	0.0467	-2.48	-0.23
5	22	0.04	0.59	4.85	0.0321	2.71	0.21
Intercept:						44.33	0.00
Model:	F = 15.22	p < 0.0001					